ABI INCIDENT REPORT FORM

To document issues that impact the health, safety, welfare, or lifestyle choices of individuals

IDENTIFYING INFORMATION: ☐ ABI ☐ ABI-LT ☐ DCBS ☐ Michelle P ☐ SCL ☐ SGF

Incident ☐ **Critical Incident** ☐

Medicaid Member ID #: _____ Name: _____ Adjudicated? ☐ Yes ☐ No

DOB: _____ Reporting Agency: _____ Provider Number: _____

Reporting Person: _____ Title: _____ Phone: _____

Case Mgmnt Provider: _____ Case Mgr Name: _____

INCIDENT INFORMATION:

Date of ☐ Incident ☐ Discovery: _____ Time: _____

LOCATION OF INCIDENT	REPORTED TO	NOTIFICATIONS (Case Mgr./Sup. Broker: Class I and II–24 hrs/Class III-8 hrs. Guardian: Class I –as directed / Class II and III– 24 hrs. Class III: DCBS–Immediate (if applicable) and DMR: 8 hrs.)		FINAL REPORT (Class II – 10 Days Class III – 7 days)
☐ Residence ☐ Job Site				
☐ Day Program ☐ Home Visit				
☐ Community ☐ Transportation Broker	Case Mgr./Support Broker	Date:	Time:	Date:
☐ Respite ☐	Regulating Agency	Date:	Time:	Date:
Address:	Guardian/Individual	Date:	Time:	Date:
	DCBS	Date:	Time:	Date:
Phone:	Physician	Date:	Time:	Date:

INCIDENT DETAILS:

What happened immediately before the incident?

What happened during the incident?

What happened immediately following the incident?

If the incident happened again, what would you do differently?

Signature of person witnessing the incident _____ Title: _____ Date: _____

INCIDENT CODES (select all that apply)

☐ A-Suspected Abuse	☐ H-Suicide Attempt	☐ P-Emergency Room Visit
☐ B-Suspected Neglect	☐ I-Severe Behavior Outburst	☐ Q-Hospitalization, Medical
☐ C-Suspected Exploitation	☐ J-Property Damage	☐ R-Hospitalization, Psychiatric
☐ D-Death of an Incident	☐ K-Self Abuse	☐ S-Medication Error
☐ E-Emergency Chemical Restraint	☐ L-Individual Aggressed to Staff	☐ T-Serious Injury
☐ F-Emergency Physical Restraint	☐ M-Peer on Peer Aggression	☐ U-Police Involvement
☐ G-Threatened Suicide	☐ N-Negative Media Attention	☐ V-CMHC Crisis Referral
☐ Other:	☐ O-Elopement	☐ W-Urgent Treatment Center Visit

☐ **Cabinet Staff Follow-Up**	☐ **Desk Level Investigation**	☐ **On-Site Investigation**

Kentucky UNBRIDLED SPIRIT

INCIDENT FOLLOW-UP

Incident ☐ **Critical Incident** ☐

(Add additional pages if necessary)

Social Security Number:_____ Name: _____ Incident Date:

Diagnoses: Axis I: _____

Axis II: _____

Axis III: _____

Recent Medical Concerns:

Does the individual have:	Yes	No
Rights Restrictions	☐	☐
Behavior Support Plan	☐	☐
Crisis Plan	☐	☐

Please list rights restrictions:

Why did this incident occur? (analysis of cause – not restatement of the information on page 1):

Individual Issues	System Issues
How many times has this kind of incident happened with this individual in the past three months?	How many times has this kind of incident happened in your agency in the past three months
What did you do to keep the person safe and well?	What system(s) or policy(ies) failed to prevent this incident from occurring or contributed to the incident occurring?
What changes will occur in the in the individual's life to prevent the incident from recurring and how will they be documented?	
	Why did this system or policy not work as was intended?
When will the individual's team meet to consider these changes?	
How should these changes be implemented?	
When should these changes be implemented?	How will the system or policy be changed to prevent recurrence?
Who should ensure these changes are implemented and followed?	
What concerns did the individual express when you talked with them about this incident?	
	When will the system or policy be changed?
How does the individual report they are doing today?	
	Who will monitor the system changes to ensure they are implemented and followed?
Signatures:	
Program Director / Supervisor	Signature:
Case Manager/Support Broker	Executive Director/MRDD Director